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Before the United States House of Representatives

Committee on the Budget

Hearings Regarding Waste, Fraud and Abuse in

Mandatory Agency Spending Programs

July 9, 2003

Mr. Chairman, Ranking Member and Members of the Committee. Thank you for giving me the opportunity to testify on the extent of waste, fraud and abuse in mandatory programs of my agency, the U.S. Office of Personnel Management (OPM). At a time in which there are so many competing demands on the federal budget, we join every taxpayer in concerns over whether funds available for mandatory federal programs are being utilized in the most efficient and effective manner. We are all concerned in identifying existing problem areas and the actions being taken to eliminate or reduce them. You have addressed your concerns to the government officials charged with responsibility to oversee their respective agency's programs and who address your questions on a daily basis---the inspectors general. I have been honored to serve successive Presidents and Directors of the OPM for over 13 years.

In its role administering benefits to government employees, annuitants, survivors and their dependents, OPM has three mandatory programs that are susceptible to waste, fraud and abuse. They are the Federal Employees Health Benefits Program (FEHBP), the Retirement Programs (RP), including both the Civil Service Retirement System and the Federal Employee Retirement System and the Federal Employees Group Life Insurance Program (FEGLI). However, it should be noted, the Thrift Savings Plan is not administered by OPM. As of FY 2002, the outlays for each of the programs were: FEHBP $24 billion; and RP $48 billion; and FEGLI $2 billion.

In understanding our role in dealing with waste, fraud and abuse, it is important to understand how these programs work. Under the FEHBP, OPM contracts with different health maintenance organizations (HMOs), employee organizations, such as the National Postal Mail Handlers Union, and the Blue Cross Blue Shield Association (the "carriers") to provide benefits to eligible persons. Payments to health care providers and suppliers are not made directly by OPM but by these organizations. Under the RP, claims are adjudicated and paid by OPM. Under the FEGLI, claims are made to a contractor who administers the program for OPM. In order to better understand the magnitude of waste, fraud and abuse in OPM's mandatory programs, each program needs to be examined separately.

The Federal Employees Health Benefits Program

My office has the responsibility under the FEHBP to audit the carriers for the purpose of identifying funds improperly paid to them under their contracts with OPM. My office also has responsibility to investigate fraudulent claims submitted to carriers by health care providers and suppliers. Each demonstrates a different level and type of waste, fraud and abuse and needs to be discussed separately.

In dealing at the insurance carrier level, I would classify these improper payments primarily as waste of government funds rather than as fraud or abuse.
At this level, OPM is justifiably proud of operating programs with relatively small amounts of waste. While improper payments amounting to about $160 million in fiscal year 2002 are not an insignificant figure, it amounts to less than one percent of FEHBP premiums paid.

Examples of improper payments made to carriers include:

- Coordination of Benefits (COB) – Carriers are not properly coordinating claim payments with Medicare as required by their contract with OPM. As a result, the FEHBP is paying as the primary insurer when Medicare is, in fact, the primary insurer.
- Duplicate Payments – Carriers are improperly charging the program for duplicate payments, such as paying a provider twice for the same services. These payments are unnecessary and unallowable charges according to the contract.
- Amount Paid is Greater than the Covered Benefit Charge – Carriers have paid more than the amount indicated in the carrier's contract with the provider.

Another area where we continue to experience waste, as well as fraud and abuse within the FEHBP is in the rate-setting process for community-rated health benefits carriers. Defective pricing occurs when the FEHBP is not offered the same discount that a carrier offers to other large groups similar in size to the FEHBP. Historically, defective pricing has been an ongoing audit and investigative issue within the FEHBP. Several cases have been referred by my office to the Department of Justice. In our September 30, 2002 semi-annual report to Congress, my office highlighted a major recovery of funds to the FEHBP in the amount of $63.9 million resulting from defective pricing which was derived from payments made over multiple years to multiple plans.

To address defective pricing issues, my office has and will continue to increase the number of audits performed on community-rated contracts. By increasing our presence at a larger number of contractors, we believe the defective pricing issues can be reduced. The success of such an increased audit presence is demonstrated by an initiative we implemented in 1996 by conducting audits of premium rate calculations for the largest carriers on an annual basis. This process was known as rate reconciliation audits (RRA). In 1996, my office questioned $6.5 million for RRAs. During the first couple of years after the RRA process was implemented, we found that 60 to 70 percent of the carriers we audited under this process were not in compliance with OPM regulations. I am pleased to say that after five years of these annual audits, the noncompliance rate has dropped to approximately 40 percent of the carriers, and the dollar amounts in question have been reduced from $6.5 million to about $2.5 million.

The largest amount of FEHBP fraud and abuse occurs at the health care provider or supplier level. My criminal investigators work with other law enforcement agencies and the carriers to identify and pursue prosecution for payments fraudulently submitted to and paid by the carriers to dishonest health care providers and suppliers. By its very nature, this fraud and abuse is hidden and therefore, difficult to detect. Adding to our difficulty in estimating the extent of provider fraud is the indirect nature of OPM's contractual relationship with health care providers. They are not government contractors or subcontractors and only have such relationships with the carriers. Therefore, my criminal investigators respond to allegations of provider fraud or abuse or irregularities detected through our audits. I do not have authority to audit health care providers generally. OPM is seeking contractual changes to provide audit authority for the very largest providers, such as pharmacy benefit managers. Therefore, I currently lack adequate information to accurately estimate the amount the FEHBP loses each year to health care provider and supplier fraud, but I do believe losses are significant and substantial.

Examples of fraud against the FEHBP by providers and suppliers include submitting false claims for services not rendered, billing for medically unnecessary procedures, falsifying billing codes that lead to a higher rate of reimbursement, and placing FEHBP patients in harms way with their illegal activities. These types of waste, fraud and abuse have been inherent in the FEHBP since the inception of the program. Despite their long-standing nature, we fight the waste, fraud and abuse every day, using new and innovative techniques as they become available and assigning resources to new problem areas as soon as they are discovered.

For example, a new problem area is pharmacy benefit manager organizations (PBMs). We are working closely with the Department of Justice to pursue waste, fraud and abuse by the PBM industry. We currently do not have statistics to quantify the magnitude of problems that may exist in the prescription drug program since our involvement in this area has just begun. But given the large amount of funds expended on prescription drugs and the increases expected, we will be focusing a significant portion of our resources on this area in the future and should have a better idea of the magnitude of fraud involving PBMs, an issue recently brought to light by fraud allegations against Merck-Medco.

Another example of action taken to reduce the waste, fraud and abuse in the FEHBP at both the carrier level and the health care provider and supplier level is a new initiative to improve our benefit payment claims review capacity. The initiative combines the use of affordable computer technology with expert knowledge in the field of health benefit analysis. The goal is to develop a data warehouse, employ program-wide review strategies, and ultimately, implement sophisticated data mining techniques to thoroughly analyze FEHBP health benefit claims payments.

We have developed an implementing strategy that has had an immediate impact on our claims analysis capabilities, while offering future opportunities for our auditors to use their expertise to discover other types of improper claims payments. We envision that this data warehouse/data mining project will significantly increase our ability to highlight trends of potential health care fraud in the FEHBP. The project will also provide our criminal investigative staff with the ability to react quickly to investigative leads. For example, our criminal investigators will be able to determine the potential program risks associated with an identified provider or subscriber fraud allegation, and take appropriate action in a matter of hours versus days or weeks.

Our current data warehouse plan centers around health benefit claims data from the FEHBP contract with the BlueCross BlueShield Association (BCBS Association). In 2002, the BCBS Association paid $10.8 billion in FEHBP health benefit payments including $3 billion for prescription drug benefits. Our ultimate goal is to include claims data from all carriers who determine premium rates using the same methodology as FEHBP-participating Blue Cross and Blue Shield plans.

We have recently implemented a series of computer claims analysis applications that our auditors are using as part of our routine BCBS Association FEHBP audits. The first application is designed to assist the audit staff in selecting a claims sample in order to verify various controls that have been established within the carrier's claims processing system. Additional applications have been designed to assist the audit staff in identifying the following types of routine claim payment errors:

- Coordination of Benefits,

- Duplicate Payments,
- Amount Paid is Greater than the Covered Benefit Charge, and
- Debarred Providers.

Prior to the development of these applications, the auditors were required to work through a single computer specialist. While we were quite successful with this approach, it limited the number of audits that could be completed annually. Now, by applying these technical advancements in computer hardware and software with the skills of our staff (computer specialists, information systems audit staff and FEHBP program auditors), we have realized two important auditing goals: First, we have made our claims analysis process more comprehensive; secondly, we have significantly increased the number of health care audits we are able to complete each year.

These user-friendly, computer-assisted audit techniques have standardized the audit process, while allowing our auditors the necessary flexibility to adjust the applications to the specific requirements of their assignments. By empowering our auditors to complete more routine computer analyses, our computer specialists, in turn, are free to concentrate on more complex issues. These specialists also have time to work on the development of our OIG data warehouse and, ultimately, our data mining applications. These computer applications can be run from remote locations throughout the country through a secure, virtual private network.

Another important new strategy in identifying potential program waste is to complete our claims analysis on a global rather than plan-by-plan basis. This approach offers us the opportunity to address significant issues one time only instead of multiple times per year and to recover overcharges to the program when appropriate. We are in the process of completing our first such global review. This first review targeted our on-going problems with improperly coordinated claims with Medicare. While we have not finalized this review, we anticipate questioning over $22.5 million in improperly coordinated claims. We have targeted other claim payment issues, such as duplicate payments, for global reviews.

One of the key components of this strategy is to work with OPM and the appropriate carriers to identify and resolve the root causes of these claim payment issues. The goal is to work cooperatively to resolve issues once and for all. With routine updates to the data warehouse, we will be able to monitor our joint efforts in resolving these global issues.

Finally, we plan to apply data mining techniques to our data warehouse to automate the process of discovering suspect trends and unusual payment patterns. Our first step has been to form a data mining team. This team, made up of a senior FEHBP program auditor and a senior computer specialist, will have the unique challenge of employing data mining software to discover relationships and hidden patterns in claims data. Using their combined technical skills, the team will use these relationships and patterns to identify potential health benefit payment errors and possible fraudulent payments. The data mining team is also supported by additional auditors with claims audit experience, as well as our OIG information systems audit unit.

The key to our ongoing success is to provide the audit and criminal investigative staff—our experts—with powerful, yet easy-to-use, computer-assisted auditing tools to combat waste, fraud, and abuse in the FEHBP with increasing effectiveness and efficiency. This initiative mixes affordable computer technology with our human capital expertise to maintain and enhance our audit and criminal investigative capabilities in a rapidly changing technical environment.

We are also combating fraud by health care providers and suppliers through our enhanced administrative sanctions and civil monetary penalty program. Since May 1993, our office has debarred or suspended over 24,000 health care providers who have committed serious violations that disqualify them from participating in the FEHBP.

New regulations effective in February 2003 expand the range of actionable violations and substantially improved the operational efficiency of our sanctions activities. We anticipate that additional regulations will become effective later this year to enable OPM to impose, through administrative action, civil monetary penalties and financial assessments on health care providers who have knowingly committed claims-related violations resulting in incorrect payments of FEHBP funds. These financial sanctions will permit OPM to recover damages and costs resulting from provider misconduct and will carry a deterrent effect to such violations among providers participating in the FEHBP.

Federal Retirement Programs

While my office focuses primarily on waste, fraud and abuse in the FEHBP, we also guard against it in the RP. The RP has an erroneous payment rate of less than one-half of one percent of payments made or about $100 million in fiscal year 2002. Most of the erroneous payments are computation errors identified and corrected by the agency itself. However, there is other waste, fraud and abuse within the RP, notably the failure to notify OPM of the annuitant/survivor's death, resulting in improper continuation of RP payments. This failure may often be due to unfamiliarity with the RP requirements. Unfortunately, it is frequently the result of deliberate fraud.

OPM has tried to eliminate the erroneous payments by routinely performing computer matches using OPM's annuity rolls and the Social Security Administration's death records. We assist the agency by proactively reviewing RP annuity records for any type of irregularity, such as reaching 100 years of age. If we discover an irregularity, we conduct independent queries with other data bases to determine if annuitants are deceased. We will continue, as necessary and as our resources permit, to actually verify that annuitants are still alive by visiting them at their residences.

As an additional measure to review the RP rolls, when we hire new criminal investigators, we will be placing them in areas of the country where large clusters of current and former federal employees reside, such as California and Florida. This provides us with additional resources for fraud referrals against the FEHBP and the RP where the criminal activity is most likely to originate.

Federal Employee Government Life Insurance Program

FEGLI is the third mandatory program which my office has a responsibility to audit and investigate for waste, fraud and abuse. However, our regular audits of the program and the financial statement audits by outside auditors demonstrate that there is not a significant amount of waste, fraud and abuse in the FEGLI. While there undoubtedly is some, I would estimate it to be less than one-tenth of one percent of FEGLI payments each year or less than $2 million a year.

At this time, we are unaware of any additional actions of an administrative or legislative nature needed to improve our ability to combat waste, fraud and abuse in OPM mandatory programs. We are pleased with the support Congress has given us in recent years by providing

effective administrative sanctions authority in the Federal Employees Health Protection Act of 1998 and providing statutory law enforcement authority for certain inspectors general offices through enactment of the Homeland Security Act. I will continue to keep you informed of our progress and future needs in our semi-annual reports and through such testimony as you may find helpful in the future. Thank you again for the opportunity to discuss the challenges, opportunities and progress that we have made at OPM in cooperation with the administration, Congress and other law enforcement agencies.